**Reclaim Joy Medical**
**4633 Old Ironsides Dr, Ste 210**
**Santa Clara, California, US - 95054-1836**

# Release of Treatment Information - rev 2

## Release of Information Form

Patient's name: *

Name of Legal Guardian if Patient is a Minor

Patient's address: *

Patient's phone number: *

I, the person stated above, give Reclaim Joy Medical permission to (check all that apply):

- ☐ Send/disclose information from the named entity
- ☐ Receive/request information from the named entity

Name of company/provider/person: *

Address of company/provider/person:

Phone number of company/provider/person: *

Fax number of company/provider/person:

The following documents are requested: *

- ☐ Medical history and evaluation(s)
- ☐ Mental health evaluations
- ☐ Most recent progress note
- ☐ Educational records
- ☐ Progress notes, and treatment or closing summary
- ☐ Verbal discussion

Requested information will be used for the purpose(s) of: *

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ Determining eligibility for benefits or program
- ☐ Coordination of care
- ☐ Transfer of care

By initialing beside, I give permission for discussion/disclosure of any Mental Health treatment, genetic testing information, any substance abuse treatment information, and any HIV testing information in my medical record. Any exceptions noted beside. *

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This release expires in two years, or the date printed beside, which ever is soonest.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 2 years this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information. *

☐ Yes ☐ No

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. *

☐ Yes ☐ No

**PATIENT / GUARDIAN SIGNATURE** *

Printed Name of Signatory *

Date signed: *